HEALTH INSURANCE IN NEW ZEALAND

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revenue financing, can be utilized to finance a comprehensive social security program, including health benefits. The New Zealand fiscal arrangements exemplify a broad and social approach to the provision of social security, wherein all residents are expected to contribute but no effort is made to achieve an exact actuarial relationship between contributions and benefits. The discussion of the cost of various health services is of value in illustrating, in financial terms, the relationship and degree of balance of the various services under a universal and comprehensive program of health insurance. Finally, the problems arising regarding the remuneration of persons and agencies providing service, and the special relationships which exist between these various professional bodies operating under a decentralized governmental administration, receive particular attention.

The report was prepared by Alex M. Morris under the supervision of John E. Sparks, in charge of the Public Medical and Hospital Care Studies in the Research Division. Editorial assistance in the preparation of the memorandum was provided by Miss Barbara J. Stewart.

Joseph W. Willard
Director, Research Division.

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I INTRODUCTION

The Social Security Act of New Zealand, 1938, increased and extended the existing system of cash payments in relation to aged persons, invalids, widows, family dependents, minors, Maori war veterans, and the unemployed. In addition, new cash benefits were introduced to cover orphans, sickness, and universal superannuation.

The Act also established a new and comprehensive system of benefits for the provision of health services, the commencement date of each class of benefit to be fixed by the Minister of Health as soon as arrangements could be completed for their effective administration. Two principal features of the program are universal coverage regardless of economic status, and the provision of benefits as a matter of right, regardless of the amount, if any, of social security taxes paid by the recipient.

By the end of 1939, maternity benefits and in-patients hospital care, including staff-specialist and diagnostic services, were inaugurated. Two years later the hospital services were enlarged to include out-patient treatment. General practitioner services, now the major benefit provided under the program, were also introduced in 1941, and drugs and supplies became available as pharmaceutical benefits. Then followed the development of certain auxiliary benefits, such as the provision for district nursing care, massage services and domestic assistance, the provision of artificial aids and, in 1948, an ambulance service. The inauguration of a limited dental program in 1946 and the provision, in 1949, for the

inclusion of full private specialist care under the program completed the present range of health benefits.

This report provides a general summary description of the health services established by the Social Security Act under the following major headings: coverage and benefits, financing, division of costs, methods and rates of payments, and administration. In addition, a short summary is given of the health services available prior to 1939.

All information given has been obtained from official government sources except where noted.

II HEALTH SERVICES IN NEW ZEALAND PRIOR TO 1939

A short account of the public and private health services in existence prior to 1939 is given below, to indicate the structure of the total health services and resources into which the health service benefits of the 1938 Act were placed.

PUBLIC HEALTH SERVICES

(1) Organization

(a) National

The administration of public health, as established under the Health Act, 1920, is largely a function of the central government. This Act established a Department of Health with a Director-General of Health as Chief Administrative Officer and including Divisions of Public Hygiene, Hospitals, Nursing, School Hygiene, Maternal Welfare, Tuberculosis and Dental Hygiene. In 1938 a new division called the Division of Health Benefits was created to administer the health benefits provided for under the Social Security Act of that year.

Under the Health Act, the Health Department is made responsible for the administration of the various public health provisions included in the Act and, in addition, exercises considerable control over the public hospital system.

(b) Regional

For the purposes of local administration, the country is divided into health districts. The significance of this regional organization of public health services to the Social Security health services will become more apparent when the administration of the health benefits is discussed. Each

public health district is in the charge of a state-employed Medical Officer of Health.

(2) Services

Before the introduction of health benefits the following services were provided free or at reduced rates by the Department as part of the general public health program:

(i) the medical inspection of all primary school children (grades 1 to 6);

(ii) dental treatment and regular semi-annual dental inspection of pre-school and primary school children;

(iii) free ante-natal services at public ante-natal clinics established at state and public maternity hospitals; hospital maternity services at reduced rates in four state maternity hospitals in cases where the husband's income did not exceed £5 per week (in cases of large families, £6 per week);

(iv) clinical treatment for all persons suffering from venereal disease;

(v) treatment in state and Hospital Board tuberculosis institutions;

(vi) treatment in state-operated mental institutions.

All these services except items (iii) and (vi) above, continue to be provided under the public health program.

(3) Public Hospitals

With the exception of services provided in state mental institutions and in a limited number of state tuberculosis and maternity hospitals, the remainder of the public

health services mentioned above are provided through the New Zealand public hospital system.

The organization of this system on a district basis, in which each district has at least one general hospital, permits the centralization of all diagnostic and treatment facilities in these institutions and dispenses with the need for special clinics outside the hospitals.

In 1938-39, there were 129 public hospitals, with a total of 9,225 beds or 5.7 beds per thousand population.(1)

Prior to the inauguration of hospital benefits in 1939, free hospitalization of the indigent sick was the legal responsibility of the public hospitals.

PRIVATE HOSPITAL AND MEDICAL SERVICES

(1) General Practitioner Services

Generally speaking, prior to the introduction of medical benefits in 1941, medical services were provided largely through the traditional methods of private practice. In 1938 there were 1,559 registered medical practitioners in New Zealand, or one practitioner for every 975 persons.

(2) Private Hospitals

Since 1907, provisions have existed in New Zealand for the licensing of private hospitals. By 1939, the year in which hospital benefits were introduced, licensed private hospitals totalled 312 and contained 2,576 beds (1,556 medical and surgical, 1,020 maternity beds), providing about 22 per cent of the total number of beds available in both public and private hospitals. Most of the private institutions specialized

(1) These beds included general, tuberculosis, maternity, infectious disease, and children's beds, but excluded mental beds.

in maternity care; maternity beds provided here amounted to almost three-quarters of the total maternity beds available in all public and private institutions.

(3) Friendly Societies

There were 1,128 Friendly Societies in existence in New Zealand prior to 1939 with an aggregate membership of 113,709 persons. According to the official New Zealand Year Book for 1946, the Societies witnessed a gradual fall in membership from 1939, losing about 25 per cent of their members by 1945. The Year Book comments, "the various benefits under the social security scheme, particularly medical and hospital benefits, have no doubt had considerable effect on the membership of Friendly Societies."

III HEALTH BENEFITS UNDER THE SOCIAL SECURITY ACT, 1938

A. COVERAGE

The coverage provided by the Social Security Act of 1938 is comprehensive in scope. The Act stipulates that "every person who is over 16 years of age and is ordinarily resident in New Zealand shall be entitled to claim for himself and for every member of his family under 16 years of age the several benefits provided for by this Part of the Act."

The eligibility requirements for one type of benefit, namely, dental care, limit the universality of coverage in that only persons under 19 years, or within the appropriate age group appointed by the Minister (at present from primary school leaving age to 16 years), are entitled to dental care.

B. BENEFITS

MEDICAL BENEFITS

Medical benefits, including general practitioner and specialist care, and X-ray diagnostic and laboratory services, are provided under the program with no limit on services rendered. The scope of the benefits, and certain excluded services, etc., are discussed below but no data are available on the utilization of the services.

(1) Medical Practitioner Services[1]

There are two distinct medical benefit schemes for medical practitioner services in operation in New Zealand

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(1) See also Section (3) following, "Specialist Services".

under the Social Security Act, namely, the "medical benefits" (capitation) scheme and the "general medical services" (fee-for-service) scheme.

The "medical benefits" or capitation scheme, providing free service to the patient, was the first of these to be inaugurated and was introduced on March 1, 1941. The regulations governing this scheme provide that medical practitioners may enter into arrangements with individual persons, and, subject to compliance with certain prescribed terms and conditions, the practitioners are then entitled to the periodic payment of capitation fees in relation to their panel lists. However, this system was generally unacceptable to the medical profession, mainly on the grounds that it would create serious problems for medical practitioners returning to private practice after service in the armed forces, and also that it imposed upon the participating medical practitioners an "unlimited and undefined liability" for medical service, for a defined cost. They considered the scheme unsuitable except for low income groups in the population.

The response by the practitioners to the capitation scheme was so poor[1] that later in the same year, by the Social Security Amendment Act, 1941, the government provided a fee-for-service scheme, "general medical services". This latter system, under which medical practitioners are entitled to receive specified fees for each occasion upon which they provide medical services, has been almost universally accepted by the profession.

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(1) The report of the Medical Services Committee 1948 states that the maximum number of medical practitioners that were ever under the capitation scheme was 51 and that the number at the time of the writing of the report was 23.

(a) "Medical Benefits" (capitation)

Scope[1]- "Medical benefits" are defined as all the proper and necessary services of a general medical practitioner. The specific services provided for the patient are:

(i) consultation or treatment in the medical practitioner's office or in the patient's home, or at any other place approved for the purpose by the Medical Officer of Health; also, a patient in hospital is entitled to visits by his own medical practitioner providing he is in an institution that permits such visits;

(ii) prescribed drugs and appliances as are requisite for the patient's health, and these to be provided by the medical practitioner in any case where they cannot be conveniently obtained elsewhere;

(iii) medical certificates or recommendations as may reasonably be required for the purpose of obtaining any medical or other treatment that is not within the scope of the obligations of the medical practitioner[2];

(iv) emergency medical service, including cases normally covered by Workers' Compensation.

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(1) Social Security (Medical Benefits) Regulations 1941. If any question arises as to whether any service provided by a medical practitioner is within the scope of "medical benefits", the Act stipulates that it shall be decided by the Minister after consultation with the appropriate committee.

(2) The Finance Act (No. 4), 1940, s. 13.

Exclusions - The following types of medical service are excluded from "medical benefits":

(i) maternity medical services;

(ii) specialist services;

(iii) medical or surgical attendance in cases where the expense of these services is covered by the Workers' Compensation Act,1922.

Procedure for Obtaining Benefits - To claim the benefits for himself or for any member of this family under sixteen years of age, or for any other person for whom he is entitled to claim the benefits, a person must make application for a Medical Benefits Card (on an Application and Agreement Form).

When the applicant has provided the information requested on the form and the form has been signed by both the applicant (or, in the case of a minor or an aged person, by some responsible person acting on his behalf) and by a medical practitioner of his choice, the person for whom the application has been made is placed on a doctor's panel and becomes eligible to receive the medical benefits immediately.

Persons who are refused medical services by one practitioner may apply to any other practitioner who is willing to provide them.

(b) "General Medical Services" (fee-for-service)

As previously stated, so few medical practitioners accepted the "medical benefits" (capitation) scheme, that a new type of medical services system, organized on a fee-for-service basis, was inaugurated under the Social Security

Amendment Act, 1941 (No. 14). The new service, entitled "general medical services", did not supersede the "medical benefits" scheme and the two systems continue to operate concurrently. The medical practitioner treatment and consultation services are identical under both schemes, but it will be noted below that there are more exclusions under "general medical services" practice than under the capitation program.

Exclusions - The following medical services are excluded from "general medical service" benefits:

(i) maternity services;

(ii) medical services provided through membership in a Friendly Society.

The following services are normally excluded but may be included in special circumstances:

(i) medical examinations to certify the condition of a person's health;

(ii) venereal disease medical services(1);

(iii) dental service as performed by a medical practitioner;

(iv) medical services provided under the Workers' Compensation Act, 1922;

(v) medical services which are provided under the X-ray diagnostic services benefits.

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(1) The treatment of venereal diseases is provided for under the Health Amendment Act, 1940. Under this Act, where treatment is not conveniently obtainable at a public hospital or public clinic, the Director-General of Health may authorize a registered medical practitioner to administer free treatment if the patient is unable to pay.

Procedure for Obtaining Benefits - In the case of the fee-for-service scheme there is no panel arrangement. Patients are free to choose and change doctors at will.

(2) Diagnostic Services

Ordinary hospital X-ray diagnostic and laboratory services formed part of the treatment services provided under the in-patient hospital benefits of 1939 (see Hospital Benefits). X-ray diagnostic services were provided to out-patients and to private patients as so-called "supplementary benefits" in 1941, and in 1946 laboratory diagnostic services were extended to out-patients and to private patients.

(a) X-Ray Diagnostic Services

Scope - The supplementary diagnostic benefits of 1941 made provision for private radiological services beyond their provision in hospital, as well as for out-patients.

Exclusions - X-ray examinations or photographs for dental purposes or for purposes of life insurance are excluded.

Procedure for Obtaining Service - Ordinarily the service performed by radiologists requires a written recommendation by the medical practitioner carrying the case, whether in private practice or in hospital staff employment.

(b) Laboratory Diagnostic Service

Laboratory services to private patients through private pathologists and to hospital out-patients were inaugurated in 1946, thus extending the public hospital in-patient laboratory services developed in 1939.

Scope - A wide range of authorized services are provided, together with necessary laboratory materials and

medical services ordinarily performed by pathologists and incidental to laboratory diagnostic services.

Exclusions - Specifically excluded from the benefits are the following laboratory services:

(i) examination of specimens for public health purposes;

(ii) post-mortem examinations;

(iii) laboratory services for dental purposes or for the purposes of life insurance;

(iv) the preparation of sera and vaccines.

Procedure for Obtaining Benefits - Laboratory services are performed on the written recommendation of a medical practitioner by or under the direct supervision of a recognized pathologist, or by a bacteriological assistant approved by the Director-General of Health under the direct supervision of a medical practitioner employed or engaged by a Hospital Board.

(3) Specialist Services

Before April 1, 1950, private specialist services other than radiological, pathological, obstetrical and neuro-surgical or those provided by specialists employed by Hospital Boards, were provided only at the fee-for-service rate of payment used for general practitioner services. The patient defrayed the remaining cost of the service.

Fee-for-service payments for private specialist medical services, at a rate considerably above the general practitioner rate, as provided under the Social Security Amendment Act, 1949, were implemented on April 1, 1950.

Procedure for Obtaining Benefits - Recognized specialist services are obtainable only on the recommendation of a general practitioner.

(a) In Public Hospitals

Scope - The following specialist services have been provided free of charge by public hospital staff specialists under the in-patient hospital benefit regulations since 1939:

(i) medicine -

general,
paediatrics,
dermatology,
tuberculosis,
psychiatry,
physical medicine;

(ii) surgery -

general,
urology,
orthopaedic,
gynaecology,
plastic or reconstructive surgery,
neuro-surgery;

(iii) obstetrics;

(iv) eye;

(v) ear, nose and throat;

(vi) pathology;

(vii) anaesthetics;

(viii) radiology.

(b) In Private Practice

Private specialist services, the same as those noted above, with the exception of neuro-surgery and the services under items (iii), (vi), and (viii), were provided until April 1950 at general practitioner rates, but are now provided at specialist rates.

MATERNITY BENEFITS

Maternity benefits in New Zealand, as authorized by the Social Security Act, 1938, commenced on the 15th of May, 1939, and include the following services:

(i) treatment in maternity hospitals; or, in lieu of hospital care, the service of obstetric nurses in the home;

(ii) the services of doctors.

(1) Public and Private Hospital Maternity Services

Scope - This benefit provides free hospital services including free delivery service in Hospital Board institutions for maternity cases. It also provides for totally or partially free services in those licensed private hospitals that have entered into contract with the Minister to provide such services.

Duration - The benefits in respect to the hospital services cover a period starting with the day of birth and the fourteen days succeeding the date of birth of the child.

Utilization of Benefit - Maternity hospital statistics from 1939, the year of inception of maternity benefits, to 1947, show that the total live births increased 51 per cent, admissions to hospital for ante-natal treatment increased by 138 per cent, and hospital deliveries increased by 69 per cent. Out of every five confinements, three now take place in public hospitals and two in private maternity homes. This may be considered partly indicative of the effect that the maternity benefits have had on the utilization of maternity hospitals.

(2) Obstetrical Nursing Services

Scope - The services of an obstetric nurse in the home (registered midwife or registered maternity nurse) may be provided in lieu of hospital care. An obstetric nurse contracts with the Minister, and undertakes to provide nursing service in a patient's home, either on a full-time basis or on a part-time visiting basis.

Duration - Service extends over a period covering the day or days of labour and the fourteen days succeeding the date of birth of the child.

Procedure for Obtaining Benefits - To obtain this service the patient simply applies to the obstetric nurse of her choice.

(3) Medical Practitioner Maternity Services

Scope - Maternity medical service benefits fall into two general classes:

(i) medical services provided in a Hospital Board hospital by a medical officer in the employ of the Board;

(ii) medical services afforded by a doctor in the course of private practice.

The specific services that private general practitioners or obstetricians or Hospital Board medical officers must provide include ante-natal and post-natal advice and treatment, and attendance at delivery.

Duration - Five ante-natal visits and one post-natal visit constitute the duration of the service.

HOSPITAL BENEFITS

Hospital benefits in respect of in-patient treatment were inaugurated in July 1939, and for out-patient treatment, in March 1941.

Provision of these benefits resulted in some difficulties for the hospitals in regard to staffing, particularly with respect to nurses and domestic staff. Furthermore, many public and private hospitals have also had a deficiency in the number of beds required to treat the public adequately and this shortage persisted in 1949.

The Annual Report of the Department of Health for 1946 commenting on the hospital staffing situation stated:

> "A serious shortage of domestic staff has been almost universal. Some hospitals have had little difficulty in maintaining an adequate nursing staff, while others, especially those in the country districts or the infirmary type of hospital, have been unable to maintain adequate nursing staffs. This had resulted, in some cases, in the closure of sections of the hospital or in the refusal to admit non-urgent patients, and, in a few cases, in inadequate care being given to patients."

It should also be mentioned that the 1946 report stated that a number of private maternity hospitals were forced to close, due mainly to a shortage of domestic and nursing staff.

By 1948 the shortage of staff was still a major problem with hospitals. The Annual Report for that year stated:

> "During the year, some 800 beds were closed in Auckland and Wellington owing to shortage of staff, while one or two wards were closed for the same reason at several provincial hospitals."

The nursing shortage has continued up to the present time and the Annual Report for 1949 commented that it still necessitates "the temporary closing down of some of the accommodation - in the aggregate, approximately 1,000 beds."

The first section following describes the scope, duration and utilization of hospital benefits for in-patients in public and private hospitals, and approved institutions; the second section describes the public hospital out-patients service.

(1) Hospital Benefits for In-Patients

(a) In Public Hospitals

With the inauguration of in-patient benefits, all persons normally resident in New Zealand become eligible for free treatment in all classes of hospitals under the control of Hospital Boards. These institutions included all general public hospitals as well as tuberculosis sanatoria, chronic hospitals, infectious disease and other special hospitals (excluding mental hospitals)(1). These institutions contained a total of 14,123 public hospital beds (1948) or 7.8 per 1,000 population(2).

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(1) Benefits for treatment at State mental institutions were established in April, 1939, but, since all mental hospital provisions have been a free public health function for many years, no special administrative arrangements were necessary in order to provide this class of benefits.

(2) Department of Health, Annual Report, 1949, p. 30.

Scope - The hospital benefits cover medical and surgical treatment, nursing care, and medical observation and examination, including laboratory and X-ray examinations.

Duration - No limitation is placed on the length of hospital treatment.

Utilization of In-Patient Benefits in Public Hospitals - There has been a fairly substantial increase in the utilization of in-patient public hospital beds since the inauguration of in-patient benefits.

Data from the Annual Health Reports indicates that the occupancy rate rose from 75 occupied beds per one hundred available beds in 1939-40 to just over 79 occupied beds per one hundred available beds in 1946-47. Furthermore, the patient-days per capita, inclusive of tuberculous cases, rose (rapidly during the first year of in-patient benefits) from 1.63 days per patient in 1930-40 to 2.20 days per patient in 1946-47, or an increase of 35 per cent.

While the increased utilization of beds is affected by a variety of factors, it seems reasonable to assume that one of the major factors was the inauguration of in-patient benefits.

(b) In Private Hospitals

In-patient treatment in private hospitals also became the subject of benefits on July 1st, 1939.

Scope - Treatment services provided are identical to those in public hospitals.

Duration - No limit is placed on the length of treatment that is provided.

Utilization of In-Patient Benefits in Private Hospitals - Private hospital beds numbered 2,640 in 1948 and represented only 16 per cent of the total of all hospital beds (16,764). Statistics on admission rates are not available, but the annual expenditures from the Social Security Fund for these benefits can be examined to provide a rough indication of the utilization of these services since the benefits commenced.

From 1940-41, the first full year of these benefits, payments from the Fund to private hospitals rose from about £141.7 thousand to £264.9 thousand in 1945-46, decreasing to £252.9 thousand in 1947-48. Although the trend has not been one of constant increase, and having in mind the effect of the 1943 service rate increase (approximately a third), it nonetheless appears that this increase in expenditures for private hospitals, indicates that hospital benefits under the Act brought increased use of private hospitals as well as public hospitals.

(c) In Approved Institutions

In addition to the public hospitals and licensed private hospitals, there is another limited class of semi-public hospitals which, in accordance with the Act, has been approved for the purposes of hospital benefits. These institutions include the Karitane Baby Hospitals conducted by the Royal New Zealand Society for the Protection of Women and Children, more commonly known as the Plunket Society, and a Home for Incurables operated under a charitable trust.

Information on the utilization experience of these seven institutions is not available; all that can be said is that, since the commencement of benefits, their expenditures have increased 13 per cent. Whether this increase has been mainly due to increased utilization of facilities or to increase in the rates of payment per patient cannot be ascertained.

(2) Hospital Benefits for Out-Patients

Scope - Out-patient treatment became the subject of benefits on the 1st of March 1941, in public but not in private hospitals[1]. Upon introduction, the benefits included all medical, surgical, or other treatment afforded to a patient by the staff of the hospital or by any person acting on behalf of the Hospital Board, except:

(i) dental treatment;

(ii) the supply of any drugs, medicines, or appliances, including dressings that are not taken by the patient or applied during treatment at the hospital but are intended for his subsequent use;

(iii) X-ray services for diagnostic purposes;

(iv) laboratory services for bacteriological or pathological purposes;

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(1) Out-Patient services in public hospitals were inaugurated under the Social Security Hospital Benefits for Out-Patients Regulations 1941, these regulations included provisions for out-patient services at two special hospitals operated by government departments, the Tourists Departments' sanatorium at Rotorua and the Health Departments' neurological hospital at Hammer Springs; the neuro-surgical cost data shown in Appendix 6 refers to this latter service.

(v) any treatment afforded to an out-patient in his own home or place or residence[1].

All of the exceptions noted above have since been brought under the Act and are now available through public hospital out-patient departments or private practitioners and are discussed elsewhere in this Chapter.

The supply of artificial aids, which has also been added, is included as a hospital benefit for out-patients and is discussed in Section (a) following.

Duration - No limitation is placed on the period of out-patient hospital treatment.

Utilization of Out-Patient Benefits - Since the commencement of the benefits on March 1, 1941, there has been a marked increase both in the number of persons utilizing out-patient services and in attendance rates.

In 1940-41, the year prior to the commencement of the benefits, there were 146 out-patients per thousand population whereas in 1946-47 this had increased by approximately 70 per cent, up to a rate of 250 out-patients per thousand population[2].

The trend towards increased utilization is further illustrated by the increase in attendance per thousand population; in 1946-47 the attendance rate per thousand population

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(1) In 1944 the Hospital Benefits for Out-Patients Regulations extended the scope of the benefits by making provision for the administration of treatment at places other than the hospitals, subject to the approval of the Minister of Health. The principal purpose of this regulation was to include certain types of specialized surgical services, (treatment for cleft palate and hare lip) performed in specially equipped private hospitals. The exclusion on benefit is now further covered by the domestic assistance benefit, "general medical services" and the district nursing care benefit.

(2) Obtained from New Zealand Official Year Book,1944,1946, and in the Appendix to the 1947 Annual Report of the Department of Health (Hospital Appendix).

had increased by about 58 per cent over that of 1940-41.

(a) Artificial Aids

The out-patient benefits regulations were amended in 1947 to include the supply of artificial aids.

Such aids include contact lenses, hearing aids, artificial limbs and certain other appliances.

Aids are provided only on the approval of hospital staff specialists.

Generally speaking, contact lenses and hearing aids are fully covered by the benefit, while artificial limbs are provided on a partial basis (80 per cent covered)(1).

DENTAL BENEFITS

Free dental service has been provided to pre-school and primary school children in New Zealand since 1921 under the School Dental Service conducted by the Dental Division of the Department of Health(2). The Dental Benefits Regulations (1946) of the Social Security Act extended this service to cover adolescents.

Coverage - Dental benefits are the only services provided under the health benefits that are not universal in their coverage. Under the Act, the benefits may be made available to persons under the age of 19 years, but at the

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(1) Further information on the total cost of artificial aids is given in the Chapter, "Division of Health Benefits Costs".

(2) Under this Service, children are brought under free treatment at school dental clinics beginning in the primer classes. The attendance of pre-school children is also encouraged. The service provides regular treatment for children up until they leave primary school (Grades I to VI).

present time they are provided only to children from primary school leaving age (Grade VI) up to the age of 16 years(1)

Scope - The dental benefit regulations provide a detailed schedule of the services covered by the benefits; these include examinations and prophylaxis (twice a year), various types of fillings, root-canal treatments, X-rays and other dental services that are approved by a Principal Dental Officer (a State-employed dental officer).

The services must be provided by:

(i) a registered dentist or a State dental nurse(2) in a State dental clinic; or

(ii) a contracting dentist pursuant to a contract under the regulations; or

(iii) a contracting authority in the Dental Department of a public hospital or in a dental school pursuant to a contract under the regulations(3).

Certain regulations under this benefit attempt to insure a continuity of dental care from the primary school level into adolescence. These regulations provide that, for children to receive treatment under the benefits, they must

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(1) As mentioned previously, pre-school and primary school dental care is a free public health service.

(2) State Dental Nurses are young women who receive two years training and are then qualified to conduct ordinary clinical operations under the general supervision of dental officers. They are qualified to fill teeth, make extractions and perform other operations that would usually be done by a professional dentist. In 1946, there were over 400 dental nurses operating under the scheme and nearly 200 additional nurses in training.

(3) The regulations stipulate that any registered dentist who wishes to provide treatment under the benefits must enter into a contract with the Minister of Health to do so.

have received treatment within the three months immediately preceding application for dental benefits, or to be in such dental or oral health as to not require any major treatment. This limitation is somewhat modified, however, by a further regulation which allows the Minister to approve, in particular circumstances, the enrollment of persons who would normally be ineligible under the above provisions.

Failure to attend for treatment or examination for any period of 12 months may render a patient ineligible to receive further benefits.

Duration - No limitation is placed on the period of dental treatment.

Procedure - When the Principal Dental Officer in each health district is satisfied that a patient is entitled to be enrolled, the Officer enrolls the patient for treatment at a State dental clinic or with a contracting dentist or contracting authority, whichever is the most convenient for the patient.

NURSING BENEFITS

Under the District Nursing Services Regulations of 1944, provision was made for the inauguration of free district nursing services. The first district nurses to supply services under the benefits were employed by the Department of Health and by the Forestry Department, their services being brought under the benefit in August 1944. The following month, district nurses employed by Hospital Boards were brought under the benefits.

The services are provided by registered nurses, nursing aids, midwives, or maternity nurses, in the employ of any Department of State, any Hospital Board or any subsidized voluntary nursing association.

It is difficult to obtain information on the scope of the present district nursing services. A circular from the Minister of Health to Hospital Boards in 1948 indicates that the anticipated services are bedside services only, in cities and urban areas with a population of at least six thousand, and in certain adjacent suburban areas. In rural and small suburban areas, it is planned that eventually district nurses employed by the Health Department, but loaned to Hospital Boards, will perform a generalized nursing care service, including both bedside care and public nursing care.

According to a Department of Health bulletin (entitled Health Benefits, 1946), the shortage of trained personnel at the present time is restricting this service. Some indication of the adequacy of the program may be had by considering the Health Department's statement that "it would appear that one nurse can care for up to 6,000 population provided the area is fairly closely settled..." Judging by the fact that 123 district nurses[1] were reported to be providing service in 1948-49, it appears that coverage had been extended to about one-third of the 1949 population.

PHARMACEUTICAL BENEFITS

Beginning in 1941, all persons in New Zealand became eligible to receive drugs and supplies free of charge

(1) Department of Health, Annual Report, 1948-49, p. 41.

upon prescription from a medical practitioner.

Generally speaking, all such supplies are provided by approved pharmacists who have entered into contracts for that purpose with the Minister of Health. Medical practitioners are authorized to provide these supplies, in a limited number of localities where pharmacies are not available.

The drugs and supplies are also available at the out-patient departments of some of the larger hospitals.

A special provision authorizes the supply of drugs for maternity cases in private maternity hospitals or, on the order of a midwife, for a home confinement. Drugs provided in such cases must not be supplied earlier than three months before the expected date of confinement and must be used only during labour or the lying-in period.

Scope - A schedule issued by the Minister and called the "drug tariff" defines the range of drugs and supplies that are the subject of the benefits; in general, proprietary medicines are not available. The "drug tariff" imposes limits on the quantities of drugs which may be supplied on any one prescription but in special cases Medical Health Officers may authorize the provision of additional drugs.

Procedure for Obtaining Benefits - The drugs and supplies can be obtained only upon the recommendation of a medical practitioner or, in cases of pregnancy, of a midwife.

Utilization - Both the volume and cost of prescriptions has risen greatly since the introduction of

pharmaceutical benefits(1). A 1938 survey indicated that the average number of doctors' prescriptions was about 2.5 million a year; this number rose to 6.5 million in the year 1949, as shown below. The statement following shows the gradual rise in both prescription volume and total cost as well as the rise in cost per prescription.

Year Ended 31st March	Number of Prescriptions During Year	Expenditure For Year	Cost Per Prescription	
		£	s.	d.
1942 (eleven months)....	2,170,000	279,968	2	7
1943 " "	3,500,000	563,247	3	3
1944 " "	4,250,000	762,198	3	7
1945 " "	4,900,000	980,237	4	0
1946 " "	5,400,000	1,133,366	4	3
1947 " "	5,882,000	1,439,686	4	11
1948 " "	6,300,000	1,558,350	4	11½
1949 " "	6,500,000	1,793,159	5	6

Source: Social Security Department, New Zealand, The Growth and Development of Social Security in New Zealand, Wellington, N.Z., 1950.

MASSAGE BENEFIT

Massage treatment benefits provided by private masseurs commenced on September 1, 1942.

Scope - The benefits make provision for obtaining free massage treatment, defined in the regulations as "the use by external application to the human body of manipulation, remedial exercises, electricity, heat, light, or water for the purpose of curing or alleviating any abnormal condition of the body" and administered by a registered masseur in the masseur's rooms or elsewhere. Only massage given by masseurs in private practice is the subject of this particular benefit.

(1) Increasing costs, and the problem of excessive prescribing, will be discussed in the section "Pharmaceutical Benefits", Chapter V.

Massage services in public hospitals form part of either in-patient or out-patient hospital benefits.

Limitations on the Scope - Treatment must be afforded not later than six weeks after the date on which it is recommended.

Duration - Not more than four weeks' treatment may be obtained upon a single recommendation. There is nothing in the regulations, however, to prevent a person from obtaining another recommendation from a medical practitioner for additional treatment.

Procedure for Obtaining Benefits - The benefit is obtained only upon the recommendation of a medical practitioner.

DOMESTIC ASSISTANCE BENEFIT

In 1944 domestic assistance benefits were made available to families during periods of incapacitation of the mother, or of undue hardship, through societies or organizations formed specifically to provide this type of assistance in homes. These organizations must apply for approval to the Minister to provide these services under the benefits, and the Minister has the power to specify the locality or localities within which the services may be provided and the classes of cases to whom they may be afforded. Householders receiving this class of benefits are not under the obligations of employers, with respect to the domestic assistants provided them.

The Social Security Fund pays a small subsidy (£3,258 in 1948-49) to assist the organizations. Apparently the service is at present a restricted one.

Scope - The terms of service (including the duties to be performed and the rates of pay) under which a domestic provides assistance in the home are fixed by agreement between the association providing the domestic assistant and the householder.

Duration - No limitation is placed on the period of services covered by the benefit for those who remain eligible.

AMBULANCE

Data on costs of the health benefits[1] indicate that payments are made for certain ambulance services as "Supplementary Benefits". Except that such services were inaugurated as benefits in 1948, no information, other than costs, is available.

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(1) See Chapter V and Appendix VIII

IV FINANCING THE PROGRAM[1]

Payments for all classes of cash and service benefits provided by the Social Security Act, 1938, are made from a special fund established by the Act, called "The Social Security Fund".

The Fund has two major sources of revenue: the social security contribution, which is a tax on gross income (both private and corporate); and transfers of money from the Consolidated Fund.

THE SOCIAL SECURITY CONTRIBUTION

Generally speaking, every person 16 years of age or more who is normally resident in New Zealand is liable for payment of the social security contribution which is defined as being a charge on salaries, wages and other income[2]. In addition, every company in New Zealand pays the social security contribution.

The collection of the social security contribution is the responsibility of the income tax authorities and there is no direct relationship between the right to receive the benefits and the contributions made.

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(1) The rate of exchange for the New Zealand £ in Canadian dollars on October 17, 1950, was approximately $2.96. It should be noted that the quantity and quality of health services that a dollar would buy in New Zealand does not necessarily correspond to the services that a similar sum would purchase in Canada.

(2) The Governor-General and/or the Commissioner of Taxes are authorized to exempt specified classes or particular persons from making the contribution under special circumstances.

(1) Methods of Payment of Contribution

In the case of employees, the social security contribution is deducted by the employer from the employee's regular wages. Special social security stamps are purchased by the employer. Affixed to the wage sheets, and cancelled as the payroll deductions are made.

Normally, contributions by the self-employed, and other persons in the class designated as receiving income other than by way of salary or wages, are made semi-annually by such persons themselves, directly to the Treasury(1).

(2) Rates of Contribution

The rate of the social security contribution on salaries, wages and other income of persons and on the income of companies is 1s. 6d. on every pound of 'income'(2) or 7.5 per cent.

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(1) If in the opinion of the Minister of Finance a charge on any income other than by way of salary or wages can be more conveniently collected by considering the income as a salary or wages, the Minister may authorize that the charge be collected on such income as if it were by way of salary or wages (i.e., by the purchase and appropriate cancellation of social security stamps by the person concerned).

(2) 'Income' of persons, as defined in the Act includes all income assessable under the Land and Income Tax Act, 1923, and non-assessable income referred to under certain specified sections of the Act, and all dividends derived from companies. Generally speaking, the income of companies refers to gross income. Other income includes the income of professional persons (doctors, lawyers, etc.) farmers and other self-employed individuals.

SOCIAL SECURITY FUND REVENUE

The total revenue of the Social Security Fund for the year 1948-49 was £51.6 million. Social security contributions brought in about £29.4 million, or about 57 per cent of the total revenue for that year. A balance of £7.2 million from the previous year was brought forward, and a transfer of £15 million from the Consolidated Fund was made. This latter amount represented approximately 29 per cent of the total revenue for the year.

SOCIAL SECURITY FUND EXPENDITURE

The total expenditure, including administrative expenditures (£729,200)(1), from the Social Security Fund amounted to nearly £42,997,000 in 1948-49. The expenditure for monetary benefits was £34,392,200 or approximately 80 per cent of the total expenditure, while the expenditure for health benefits was £7,875,400, or about 18 per cent of the total.

The total Social Security Fund expenditures in 1948-49, amounted to almost 31 per cent of total government expenditure and about 10 per cent of the national income.

(1) Health Benefit Expenditures

For both 1948-49, when the total expenditure for health benefits was £7,875,400, and 1941-42, when the total was £2,435,500, the health benefit expenditures represented

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(1) This sum does not include the administrative costs for health benefits; see footnote (1) on the following page.

about 18 per cent of the total for all benefits provided under the Social Security Act[1].

The per capita cost of the various classes of health benefits was £4/5/- for the year 1948-49 as compared to £1/10/- in 1941-42.

It is noted that health benefit expenditures in 1948-49 were about 3¼ times those of 1941-42. Several factors have been instrumental in the large increase in expenditure, some of the more important of them being: (1) increases in the rates of payment for various benefits, e.g., maternity and hospital; (2) increases in the utilization of health services; (3) increases in the cost of supplies, e.g., pharmaceutical benefits.

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(1) The administrative expenditures for health benefits are met by the Department of Health as part of the total administrative costs of the Department and therefore cannot be separated out for discussion here.

V DIVISION OF HEALTH BENEFIT COSTS[1]

The largest single item of expenditure for the several classes of health benefits provided in 1948-49 was in respect of medical benefits. Expenditure in this area accounted for almost one-third of the total expenditures for all benefits. Hospital benefits accounted for one-quarter of the total expenditure and represented the second largest item of expenditure. The expenditure for pharmaceutical supplies was the third largest, accounting for more than one-fifth of the total payment from the Fund. Finally, maternity and supplementary benefits were about equal in terms of the expenditure incurred; each accounted for slightly over one-tenth of the total expenditure for all benefits.

As shown in Table I following, there was an increase in the proportions expended on medical, pharmaceutical and supplementary benefits while a decrease was experienced in the proportions expended on maternity and hospital benefits, when the years 1941-42 and 1948-49 are considered. An analysis of the many factors effecting these changes in the proportions expended on the various benefits is not attempted in this report.

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(1) See Appendices III to VIII.

TABLE I

PERCENTAGE EXPENDITURES, AND PER CAPITA COSTS,
BY TYPE OF HEALTH BENEFIT
NEW ZEALAND, 1941-42 AND 1948-49

Type of Benefit	Expenditures for Benefits as Percentages of Total Expenditure for All Health Benefits		Per Capita Cost 1948-49		
	1941-42	1948-49			
			£.	s.	d.
Maternity	22.57	11.63		9	10
Medical	11.53	29.30	1	4	11
Hospital	56.46	25.36	1	1	7
Pharmaceutical	11.52	22.77		19	4
Supplementary	1.14	10.95		9	4
TOTAL	100.00	100.00	4	5	0

Source: Compiled from statistics appearing in 1948 Annual Report, Dept. of Health, New Zealand, and in "Budget", New Zealand, 1949.

The percentage expenditures for the various classes of benefits have been given above. A more detailed discussion of the major benefit costs now follows. It should be pointed out that throughout the following sections discussing costs, such services as radiological, dental, laboratory, and district nursing (previously discussed under separate headings in the section entitled "Benefits") have been grouped together here under the major title "Supplementary Benefits".

(1) Medical Benefits[1]

As indicated in the preceding section, the expenditure for medical services now represents the largest proportion of

[1] See Appendix IV.

the total expenditure from the Social Security Fund for all classes of health benefits. The total 1948-49 cost for medical services, which included fee-for-service and capitation charges of medical practitioners, mileage fees, and remuneration of salaried practitioners (see chapter V) was about £2.3 million; the total cost of such services during 1941-42, the first year of the benefits, was £0.2 million(1).

Payments under the fee-for-service medical scheme in 1948-49 accounted for about 90 per cent of the total expenditure for medical practitioner services. Payments under this scheme have consistently been the major item of expenditure of all medical practitioner services since their inception in 1941. In 1942-43, the first full year in which fee-for-service was in operation, payments accounted for over 80 per cent of the total expenditure for practitioner services; this proportion gradually increased, until in 1948-49 it represented over 90 per cent of the total expenditure for medical practitioner services (see Table II).

Payments for doctors operating under the capitation scheme represented only 7 per cent of the total expenditure for all medical practitioner services in 1942-43, and dropped to less than 1 per cent in 1948-49. This decrease in the proportion of total expenditure for capitation fees reflects the almost total discontinuance of practice under this scheme by doctors during the past few years.

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(1) Medical benefits under the capitation scheme were introduced in March, 1941, but benefits under the fee-for-service scheme were not provided until November 1941.

TABLE II

PERCENTAGE EXPENDITURES, BY TYPE OF MEDICAL PRACTITIONER PAYMENT NEW ZEALAND, 1942-43 AND 1948-49

Type of Payment	Percentage of Total Medical Practitioner Service Expenditure	
	1942-43	1948-49
Fee-for-Service	81.33	91.57
Capitation	7.00	0.73
Mileage Fees	6.30	5.37
Salaries and Miscellaneous	4.87	2.34
TOTAL	100.00	100.00

Source: Adapted from the 1949 Annual Report.

Per capita Cost - The per capita cost of all private practitioner services was £1/4/11 in 1948-49, compared to about 12s. in 1942-43.

(2) Maternity Benefits(1)

The total expenditure for maternity benefits amounted to approximately £0.9 million in 1948-49, representing about one-ninth of the total expenditure for all health benefits and an increase of approximately 80 per cent over the 1942-43 amount. Along with the increase in cost from about £0.5 million in 1942-43 to approximately £0.9 million in 1948-49, there has been a gradual decrease in the proportion of the total expenditure for health benefits expended on maternity benefits, due to the gradual implementation of new benefits.

(1) See Appendix V.

The two major items of maternity benefit costs in 1948-49 were:

(i) hospital fees which accounted for about 68 per cent of the total maternity benefit expenditure as compared to 63 per cent in 1942-43 (public hospital maternity fees increased from 22 per cent in 1942-43 to 43 per cent in 1948-49, while private hospital fees decreased from 41 per cent to 25 per cent during the same period.

(ii) medical practitioners' fees (including mileage fees) which represented approximately 33 per cent of the total expenditure compared to 32 per cent in 1942-43.

The expenditure in respect of obstetric nursing services in 1948-49 represented only a very small fraction of the total expenditure for the year - less than one per cent.

Per Capita Cost - The per capita costs of maternity treatment provided through public hospitals, medical practitioners and private hospitals in 1942-43 were 1.34 s., 1.99s., and 2.53 s, respectively; in 1948-49 the per capita costs for these services were 4.2 s., and 3.2s., and 2.4s., respectively.

The marked increase in per capita cost for maternity benefits provided in public hospitals from 1942-43 to 1948-49 and the almost negligible change in the per capita costs of the benefits provided in private maternity hospitals (despite a considerable increase in hospital operating costs), during the same period, is indicative of the trend toward fewer

private maternity hospitals and the extension of facilities for maternity care in public hospitals.

(3) Hospital Benefits[1]

Since the introduction of health benefits in 1939, hospital benefits have consistently been one of the largest items of expenditure among the several classes of benefits provided. In 1939-40 when hospital and maternity benefits were the only two health benefits in effect, the expenditure for hospital benefits, amounted to approximately £750,000 and accounted for about 75 per cent of the total expenditure for health benefits that year. By 1941-42 when all the major classes of health benefits had been inaugurated, the expenditure for hospital benefits, which was about £1.4 million, still accounted for about 56 per cent of the total expenditure. By 1948-49, due to the extension and increased utilization of the various other health benefits, the amount expended for hospital benefits had dropped to a point where it represented only 25 per cent of total benefit expenditure. At the same time, however, there was an increase in the actual amount of money expended on this class of benefits; the outlay for hospital benefits increased to the point where in 1948-49 it was just under £2 million.

The three largest items of expenditure under hospital benefits, in order of their magnitude, have consistently been those for public hospital services, private hospital services and out-patient services. There has been

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(1) See Appendix VI.

a fairly marked increase in the per capita cost of in-patient and out-patient services in public hospitals, while the per capita cost of services in private institutions has increased only slightly. This again reflects the trend that has been mentioned before, namely, increased utilization of public hospital facilities and reduced utilization in private hospitals. The 1948-49 expenditures for the various services provided are compared with those of 1942-43 in Table III.

TABLE III

PERCENTAGE EXPENDITURES AND PER CAPITA COST, BY TYPE OF HOSPITAL BENEFIT SERVICE, NEW ZEALAND, 1942-43 AND 1948-49

Type of Service	Percentage of Total Hospital Benefit Expenditure		Per Capita Cost			
	1942-43	1948-49	1942-43		1948-49	
			£	s.	£	s.
Public Hospital	66.21	78.13		12.44		16.86
Private Hospital	12.44	12.27		2.34		2.64
Out-patient	4.59	7.09		0.86		1.52
Approved Institutions	2.52	2.52		0.47		0.54
Contributions to State Hospitals(a)	14.24	(abolished)		2.68		(abolished)
TOTAL	100.00	100.00		18.79	1	1.58

(a) These contributions were made from the Social Security Fund to the Consolidated Fund for mental hospitals and other State hospitals up until 1945-46 when they were abolished.

Source: Compiled from Yearbook, 1944, and Department of Health, Annual Report, 1949.

The increasing cost to the Social Security Fund for in-patient hospital treatment is further illustrated by

the following data on the average cost per patient-day and the average cost per case of hospital benefits for the years 1946, 1947 and 1948.

	1946 £	1947 £	1948 £
Average cost per patient-day	18/6	1/4/1	1/8/3
Average cost per case	25/8/-	26/14/1	30/10/-

Hospital Financing in Relation to Social Security Fund - Although an analysis of public hospital financing is not pertinent to this report, it is important to note the percentage of the total public hospital expenditure (including both capital and maintenance expenditure) that is provided for hospital and other benefits by way of payments from the Social Security Fund(1). Estimates of the total revenues and expenditures of public hospitals for the year 1948-49 indicate that payments from the Social Security Fund for hospital and other benefits will constitute approximately 28 per cent of the total capital and maintenance expenditure for the year(2). It is also important to note that the subsidies to public hospitals from the Consolidated Fund represent a large percentage of the total expenditure - based on the available estimates, they will constitute approximately 53 per cent of the total public hospital expenditure for 1948-49. When the Social

(1) Including out-patient diagnostic services, artificial aids, district nursing etc.

(2) Calculated from estimates on public hospital receipts and expenditures appearing in the Department of Health Annual Report 1949, p. 29.

Security Fund payments are added to these subsidies from the Consolidated Fund, it is seen that the public hospitals will have received about 80 per cent of their total expenditure for 1948-49 from these two government sources. The remainder of the revenue comes from levies on local authorities and donations, etc.

(4) Pharmaceutical benefits[1]

The total expenditure for pharmaceutical benefits in 1948-49 was approximately £1.8 million, representing a per capita cost of 19s. 4d. Expenditure for this class of benefits accounted for approximately 23 per cent of the total expenditure for all health benefits for that year. Practically all of the expenditure (about 96 per cent in 1948-49) is made as payments to chemists providing the pharmaceutical supplies; institutions and medical practitioners provide only a small fraction of these supplies.

During the first full year of their operation, 1942-43, the expenditure for pharmaceutical benefits was only about a half a million pounds and the per capita cost was about 7s. By 1948-49 the expenditure had increased over the 1942-43 amount by nearly 220 per cent, a fact which has received the greatest publicity of any of the difficulties encountered in the provision of the various health benefits. The marked increase in the cost of pharmaceutical benefits since 1942-43 has been given considerable attention also by the Medical Services Committee in the course of their inquiry into the provisions of the health benefits legislation affecting medical practitioners.

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(1)

According to the findings of the Medical Services Committee, which was set up by the Minister of Health in 1947 to examine the workings of the health benefits section of the Social Security Act, several factors contributed to the increasing expenditure for pharmaceutical benefits. The principal factors set out in the Committee's report were:

(i) over-prescribing by doctors;

(ii) the increased general use of new and expensive drugs in recent years;

(iii) the unnecessary selection of the more expensive forms of medication by doctors and the prescribing of excessive quantities of drugs by some doctors;

(iv) the unnecessary waste of medicine through loose methods of sanctioning repeats of prescriptions;

(v) increase in the wholesale cost of drugs, labor costs, and greater duty and sales taxes resulting in increased prescription prices;

(vi) many items previously bought without prescriptions are now prescribed(1).

It is important to note that certain recommendations made by the Committee were designed to act as a deterrent against unnecessary utilization of the benefit by the public as well as unnecessary or over prescribing by medical practitioners. These recommendations included: the adoption

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(1) Report of the Medical Services Committee 1948, p. 11.

of the principle of part payment by the patient of the cost of prescriptions except in certain specific cases (e.g., the supply of insulin to diabetics); the revision and extension of the Drug Formulary issued by the Department, and its general adoption as a pattern for economy in prescribing; and, finally, the extension and greater application of the existing machinery for the prevention of abuses(1).

(5) Supplementary Benefits(2)

Benefits within this class were instituted at intervals from 1941 onwards, and as their number increased their cost as a percentage of the total cost of all the health benefits increased as well. In 1942-43, when only two types of supplementary benefits had been inaugurated, namely, radiological and massage services, the total cost was just under £100,000 which represented only slightly over one per cent of the total cost of all the health benefits at that time. The radiological services accounted for about 90 per cent of the total 1942-43 supplementary benefit expenditure. By 1948-49 nine types of benefits were being provided under this class and the total cost for their provision was somewhat over three-quarters of a million pounds, this amount representing about 11 per cent of the total expenditure for all the health benefits in that year.

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(1) Such machinery is contained in the Social Security (Pharmaceutical Supplies) Regulations, Amendment No. 2, which empowers the Minister to impose penalties on medical practitioners who have been found guilty of over-prescribing after investigation by an appropriate committee.

(2) See Appendix VIII.

The per capita costs of the radiological and massage services in 1942-43 were approximately one shilling and one-tenth of a shilling, respectively. The total per capita cost of the various supplementary benefits in effect in 1948-49 was about nine shillings.

As shown in Table IV, the six types of supplementary benefits that accounted for practically all of the expenditure for this class of benefits in 1948-49 were, in order of magnitude, radiological, dental, laboratory, district nursing, aritificial aids and massage. The expenditure for the three other services, specialist (neuro-surgery), domestic assistance and ambulance was almost negligible.

TABLE IV

PERCENTAGE EXPENDITURES AND PER CAPITA COST, BY TYPE OF SUPPLEMENTARY BENEFIT SERVICE, NEW ZEALAND, 1948-49

Type of Service	Date of Commencement	Percentage of Total Supplementary Benefit Expenditure 1948-49	Per Capita Cost
			s.
Radiological	1941	28.94	2.69
Dental	1947	25.89	2.41
Laboratory	1946	13.59	1.27
District Nursing	1944	12.91	1.20
Artificial Aids	1947	11.51	1.04
Massage	1942	6.62	0.62
Specialist (neuro surgery)	1943	0.47	0.04
Domestic Assistance	1944	0.38	0.04
Ambulance	1943	0.04	0.004
TOTAL	....	100.00	9.31

Source: Compiled from Year Book, 1944, and Department of Health, Annual Report, 1949.

VI METHODS AND RATES OF PAYMENT

MEDICAL BENEFITS

(1) Medical Practitioner Services

(a) "Medical Benefits" (capitation)

Method of Payment - Under this scheme, the medical practitioner contracts with the government to provide free medical services to patients who enter into an agreement with him to receive such services. The doctor is paid a specified fee per annum from the Social Security Fund for each patient for whom he agrees to provide services.

For every patient on the doctor's panel list on the 15th of each month the doctor receives one-twelfth of the annual capitation fee and also one-twelfth of the annual mileage fee for which he is credited.

Rates of Payment - The doctor is paid a capitation fee at the rate of 15s. per annum for every person on his list. No limit is placed on the number of patients a doctor can accept, under the capitation plan. Mileage fees are also payable where prescribed conditions are satisfied.

Mileage Fee - Prior to July 1, 1950, mileage fees for practitioners providing services under the "medical benefits" (capitation) plan were computed on the basis of the travelling distance between the patients' residence and the nearest residence or office of any medical practitioner. These fees were not payable (a) in cases where the patient resided in a borough in which any general medical practitioner resided or had his main office, (b) for travelling distances

that were less than three miles or that portion which exceeded twenty miles.

Subject to the above limitations, mileage fees were payable at the rate of 2s. per annum for each mile of the travelling distance (one way only) for each patient on the doctor's panel, regardless of whether travelling visits were actually made. By a 1950 amendment of the "medical benefits" regulations(1) these earlier provisions were replaced and, commencing on July 1, 1950, the mileage fees to practitioners under the "medical benefits" (capitation) plan became the same as those provided practitioners under "general medical services" (fee-for-service) (see section (b) following).

(b) "General Medical Services" (fee-for-service)

Methods of Payment - Under this scheme two optional methods of payment, namely, the direct payment and refund methods, were in operation prior to the Social Security Amendment Act of October 1949. By this legislation the refund method was discontinued generally on April 1, 1950, and the direct payment method now constitutes the principal method of payment(2).

In view of the importance of the whole question of remuneration however, both of the above mentioned methods

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(1) The Social Security (Medical Benefits) Regulations 1941, Amendment No. 2, Serial Number 1950/80.

(2) By regulation entitled "Commencement of Part III (Medical Services) of the Social Security Amendment Act, 1949", Serial Number 1950/60.

are discussed below; as well, some of the major problems in this area are outlined.

(i) Direct Payment Method

Direct payment allows the medical practitioner to make a direct claim on the Fund for services he has given. The fees that he may claim are specified in the regulations, there being different rates for consultations and visits on week days (7s. 6d.), than for those on Sundays or for night calls (12s. 6d.). Medical Officers of Health may request practitioners to furnish explanatory statements in relation to any claims they make. Although practitioners have always been legally obliged under the "general medical services" scheme to accept payment from the Fund in full satisfaction of their charges - and presumably it was therefore illegal to charge patients an additional fee - in practice, an additional charge of 3 shillings, a so-called "token" payment, was"allowed", to bring the total of the physician's fee up to that previously charged in private practice. Recent efforts to control this practice are discussed below under (iii) Problems of Remuneration, following.

(ii) Refund Method

Under this method of payment, now abolished except in special cases, the patient paid a fee (usually 10s. 6d. - the amount previously charged under private practice) to the medical practitioner for the services provided and then claimed a refund from the Fund. Regulations, however, limited the money that was refunded to a sum not exceeding

the total amount that the practitioner would have been entitled to receive directly from the Fund, i.e., 7s. 6d. This again illustrates the operation of "token" patient payments.

Rates of Payment - Fees are paid from the Fund for "general medical services" at the following statutory rates:

(i) 7s. 6d. for each consultation at the practitioner's office or visit to the patient's residence during any week-day; replaced under the Social Security Amendment Act 1949 by "a reasonable fee not exceeding 7s. 6d."

(ii) 12s. 6d. for services afforded on Sundays or between the hours of 9 P.M. and 7 A.M. on any other day.

The Medical Officer of Health may approve a claim for a higher fee, if the service involves more than thirty minutes of the practitioner's time.

Mileage Fees - A mileage fee of at least 1s. 3d. per mile is paid for every mile travelled in going to and returning from a visit to a patient's residence, except in certain cases. This fee, as was mentioned previously, now replaces that formerly paid under the "medical benefits" (capitation) scheme. Mileage fees are not paid for visits to patients living more than twenty miles from the practitioner's office or residence, or for visits to patients who live in a borough in which a practitioner lives or has his office located.

Problems of Remuneration - When medical benefits were first inaugurated, the medical profession maintained that the direct payment method of remuneration damaged the traditional doctor-patient relationship and generally was opposed to it; the government, however, was dissatisfied with the refund method (the method which the profession favored), on the grounds that its administration involved a large amount of routine clerical work. The direct payment method has been favored by the government in that it is comparatively easy to make all payments for medical services directly to the doctors. The Medical Services Committee (1947), a special Advisory Committee, comprised of members of the medical profession and the Department of Health to advise the Minister on matters affecting the services of medical practitioners, included in their final report a recommendation which was an attempt to resolve the controversy that had existed over the two methods of payment under the fee-for-service system. Their recommendation was that, in lieu of the alternative fee-for-service methods of payment from the Fund (namely, direct payment and refund), there be adopted only one method, a modified form of direct payment by which the medical practitioner would be required to claim on the Fund on behalf of the patient the appropriate amount payable from the Fund for the service, and apply that amount in full or part settlement of his charge for the service(1).

While the Committee and the Government agreed that some form of direct payment was the proper method, the

(1) See Report of the Medical Services Committee, New Zealand, 1948, p. 5.

Amendment Act of 1949 failed to recognize the Committee's modified version of "direct payment" and provided that, except in special circumstances where the refund system might be authorized, straight direct payment would be used. According to a recent official publication(1), this legislation, generally abolishing the refund method, was in accordance with a post-war trend by the medical profession to direct payment or direct payment plus token payment. Young ex-service practitioners, new graduates, and physicians from abroad beginning practice in New Zealand, found that this method assisted them in establishing substantial practices in a comparatively short time; also, other practitioners have apparently concluded that direct payment permits a greater economy in collection of accounts. In 1949, about 66 per cent of the practitioners favored the direct claim or token system.

Another problem in relation to the provision of medical services, to which the Medical Services Committee gave attention, was the illegal custom by practically all of the general practitioners operating under the "refund" system, and a number of those operating under the "direct payment" system, of regularly requesting additional charges from patients (the "token" payments previously mentioned). The Committee reported that patients, as a rule paid these

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(1) Social Security Department, New Zealand, The Growth and Development of Social Security in New Zealand, Wellington, N.Z., 1950.

additional charges readily and that the statute prohibiting this practice was a source of dissatisfaction on the part of a considerable number of the profession. It recommended therefore that every general medical practitioner should have the right to charge a fee additional to that payable from the Fund, wherever circumstances, in the opinion of the practitioner, warranted it. The Social Security Amendment Act 1949, however, while not supporting the Committee's proposal, removed a previous restriction on the practitioner's right to sue for recovery, and established legal machinery to assert this right.

A further difficulty mentioned in the Medical Services Committee's report in regard to the provision of medical services under the fee-for-service system of payment has been the tendency for certain practitioners to deal with unduly large numbers of patients in their offices and to refrain from making visits to the patients' homes. This tendency was attributed to the fact that, under the existing arrangements there was no difference in the fees paid for service performed in the patient's home to those paid for service in the practitioner's office. The Committee recommended that a distinction should be made in this regard and that a higher fee be provided for home visits. This recommendation was not included in the most recent legislative amendment to the principal Act.

(2) Diagnostic Services

The methods and rates of payments for radiologists and pathologists are dealt with in a section to follow

entitled "Supplementary Benefits."

(3) Specialist Services

Method of Payment - Persons who receive specialist services, other than those provided by radiologists, pathologists, obstetricians and neuro-surgeons, pay fees for such services, and are entitled to receive a refund from the Fund of a specified amount for each such service.

Rates of Payment - Until April 1, 1950 only the services provided by specialists employed by Hospital Boards were available at no cost to the patient. So far as private specialist services were concerned, substantial benefits (defraying most of the cost to the patient) were provided only for radiological, pathological, neuro-surgical and obstetrical services[1]; for the services of all other classes of specialists in private practice, only the 7s. 6d. fee that had been set for general practitioner services was refunded by the Fund. This meant that patients receiving all types of private specialist services, with the exception of the four noted above, were required to pay the difference between the 7s. 6d. allowed from the Fund and the prevailing private specialist fees, in 1948 £2. 2s. for an initial consultation and £1.1s. for subsequent consultation[2]. The Social Security Amendment Act of 1949, in accordance with

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(1) Provided by the Social Security (X-Ray Diagnostic) Regulations 1941, the Social Security (Laboratory Diagnostic Services) Regulations 1946, the Social Security (Hospital Benefits for Out-Patients) Regulations 1941, and the Social Security (Maternity Benefits) Regulations 1939.

(2) Report of the Medical Services Committee, 1949.

the recommendations of the Medical Services Committee, made provision for fee-for-service payments for specialist medical services (implemented on April 1, 1950), at a rate above the general practitioner rate previously paid these specialists(3).

(4) Salaried Service

Methods and Rates of Payment - The Minister of Health is empowered under the Act to make special arrangements to provide medical services, mainly by salaried medical officers, for people living in remote areas. The salaries offered range from £1,100 to £1,700 per year and the doctors are also permitted to charge fee-for-service for patients not ordinarily resident in the district. Eighteen physicians were in the salaried service in 1946.(1)

MATERNITY BENEFITS

(1) Hospital Maternity Services

(a) In Public Hospitals (including the services of hospital-employed medical officers.)

Methods of Payment - Payments are made from the Fund to Hospital Boards for maternity hospital services afforded in institutions under their control, after the Boards have submitted payment claims. The Boards are required to accept payment in full satisfaction of their claims.

Rates of Payment - The initial rates of payment to Hospital Boards for maternity hospital treatment, fixed by regulation in 1939, were: the sum of £2.5s. for the day or days of labour; 12s.6d. per day for each of the fourteen

(1) MacLean, H., and McHenry, I.E., "Medical services in New Zealand", Milbank Memorial Fund Quarterly, Vol. XXVI, No. 2, 1948.

days succeeding the date of the birth of the child; and an additional fee of £2 in the case of patients actually attended during labour and at delivery by a medical officer employed by the Hospital Board.

In 1947 the present rates were introduced, which allow £1 for the day of the birth of the child and £1 for each of the fourteen days succeeding the day of birth. This meant an increase in the benefit from a maximum of £11 (£2.5s. for the day or days of labour plus 12s.6d. per day for fourteen days) to a maximum of £15 (£1 for the day of birth plus £1 per day for fourteen days). The additional fee of £2 paid Hospital Boards for medical attendance during labour and delivery was maintained.

(b) In Private Hospitals

Private contracts exist between the licensees of licensed maternity hospitals and the Minister, to provide maternity hospital services. Licensees are entitled to claim payments from the Social Security Fund for maternity hospital services that have been provided, and are required to accept such payments either in full or partial satisfaction of their charges, depending upon the conditions of contract(1).

Rates of Payment - Payments to private maternity hospitals are at the same rates as those paid to Hospital Boards except that the additional fee of £2 for the attendance of a medical officer is not provided.

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(1) In 1943, only 31 of the 201 private maternity hospitals under contract accepted the social security payment as payment in full.

(2) Obstetrical Nursing Services

Methods of Payment - Payments in full settlement for services are made directly from the Fund after claims have been submitted by the nurses to a Medical Officer of Health.

Rates of Payment - A registered midwife acting without a doctor receives a fee of £2 for her services on the day or days of labour, while an obstetric nurse or a midwife, acting with a doctor, receives £1 for this period.

For each of the fourteen days immediately following the date of birth of the child, a visiting obstetric nurse, providing part-time services, receives 7s.6d., while an obstetric nurse providing services on a full-time basis in the patient's home is paid 18s. In addition, nurses are permitted to charge the Fund for travelling expenses incurred in connection with the service.

(3) Maternity Services Provided by Private Medical Practitioner

Methods of Payment - When maternity benefits were first introduced, the general arrangement for the provision of medical services by doctors in private practice was a form of contract between each individual doctor and the Minister of Health.

Contracts were first offered in May 1939 but the response by the doctors was very poor. The government found it necessary to revise the provisions in order to gain the support of the doctors. These revisions were incorporated in the Social Security Amendment Act passed in October, 1939.

This Act, which embodies the present scheme, provides that every doctor undertaking maternity work in the course of his practice will be entitled to receive payment from the Social Security Fund according to a scale of fees fixed by agreement between the Minister of Health and the Council of the New Zealand Branch of the British Medical Association. The fee schedule sets out the range of service and also provides for mileage fees within certain limits. Every doctor affording services covered by the scale of fees must accept the fees from the Fund as full payment with two exceptions, (a) doctors who notify the Minister they will not provide services under the Act and, (b) obstetric specialists who are permitted to charge the patient over and above the basic fee.

Rates of Payment - The fee for medical services, which includes ante-natal and post-natal advice and treatment, was originally set at £5. 5s. but was raised to £6. 6s. in 1946. In order to collect the full maternity fee, the doctor must report five ante-natal and one post-natal attendance and must have been present at delivery.

The patients of doctors who have notified the Minister that they are unwilling to afford the maternity services (there were only six doctors in this class in 1945) remain liable for any fees charged by these doctors.

As mentioned above, officially recognized obstetric specialists, whose names are published for general information, are permitted to charge the patients an additional fee.

Payment from the Fund is also made for medical services in relation to miscarriage, provided the patient has

received approved ante-natal advice before the occurance of the miscarriage.

HOSPITAL BENEFITS

(1) For In-Patients

(a) In Public Hospitals

Method of Payment - Payments are made following a monthly submittal of claims by Hospital Boards to the Fund. Again, these payments must be accepted by the Boards in full satisfaction of the charges.

Rates of Payment - When the benefits were first introduced the rates of payment were as follows:

(i) in all cases in which treatment was given for not more than two days, 12s.;

(ii) for all other cases in which treatment extended for a period longer than two days, a rate of 6s. a day was established.

On April 1, 1943, these rates were superseded by the current rates as follows:

(i) for all cases in which treatment is given for not more than two days, 18s.

(ii) for all other cases in which treatment extends for a period longer than two days, a rate of 9s. a day is paid[1].

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(1) This amount does not meet the full per diem cost but rather that portion of the cost (approximately one-third) which in 1939 was being recovered from the patient. The remainder of the cost is borne by local rates and by subsidy from the Consolidated Fund.

(b) In Private Hospitals

Method of Payment - The payments for in-patient treatment in private hospitals are made monthly from the Social Security Fund to the Licensees of private hospitals after claims have been submitted and supported by the patients' certificates. The licensees are required to apply the payment from the Fund toward the cost of the patients' fees, but they are permitted to make extra charges to the patient over and above the amount of the benefit since the 9s. per diem benefit rate does not meet the entire cost of treatment and also since the private hospitals have no taxation revenues.

Rates of Payment - The same rates for public hospital in-patient services apply to treatment in the private hospitals, i.e., the sum of 18s. for treatment not exceeding a period of two days and 9s. a day for treatment extending beyond a two-day period.

(c) In Approved Institutions

Methods of Payment - As in the case of the other types of hospitals providing in-patient services, payments to "approved institutions" are made from the Fund to the authorities[1] in charge, in full satisfaction of their charges.

Rates of Payment - Rates of payment to these institutions are the same as those paid the other types of hospitals.

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(1) Six of the seven institutions within this class are operated by the Royal New Zealand Society for the Protection of Women and Children while the seventh is controlled by a charitable trust.

(2) For Out-Patients

(a) In Public Hospitals

Methods of Payment - Payments to Hospital Boards for out-patient treatment are made from the Fund at intervals of not more than three months. Apart from one type of service (see Section (b) below), Hospital Boards are prohibited from charging out-patients for treatment.

Rates of Payment - The amount to be paid by the Fund for out-patient care was initially set, by regulation, at a sum that would cover not less than half and not more than two-thirds of the total expenditure. In 1947 this earlier arrangement was changed by dropping the limiting clause that stated that Fund expenditure should not exceed two-thirds of the total expenditure[1]. This means that the Fund now may be called upon to pay anything from 50 to 100 per cent of the total expenditure, but it appears that in practice it pays approximately 60 per cent.

(b) Artificial Aids

Methods and Rates of Payment - As this type of benefit is provided under the out-patient hospital benefits, through out-patient clinics in public hospitals, payments from the Fund are made to the controlling Hospital Boards.

The rates of payment for contact lenses is £40 per set and the rate for approved types of hearing aids[2] is £13,

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(1) In this instance, total expenditures include salaries and wages, materials, etc., and other direct expenditure which can be related to out-patient departments.

(2) Patients desiring hearing aids other than the approved types are paid up to £13 for any other hearing aid approved for the purposes of the benefit. This amount is paid the patient from the Board so that he may obtain the hearing aid elsewhere, and the Board later recovers the amount from the Social Security Fund.

with no extra charge to the patient. With regard to artificial limbs, however, the Fund provides 80 per cent of the cost of manufacture with the remainder being met by the patient or, in certain circumstances, by the Hospital Board.

PHARMACEUTICAL BENEFITS

Methods of Payment - The general procedure affecting claims on the Fund is as follows:

Persons receiving prescribed medicines or drugs are required to sign the prescriptions as evidence of having received these benefits.

Druggists submit claims twice monthly for all prescriptions they have filled along with the signed prescriptions to the nearest Pricing Office (four of these offices set up in the larger centres check the claims and make payments on them). Subject to check by the Pricing Office the druggists may price their own prescriptions according to the rates of payment shown in the Drug Tariff, or they may leave the pricing entirely to the Pricing Office.

Payments for drugs prescribed to out-patients in Hospital-Board institutions are made on the same basis as for contracting pharmacists. The regulations make special provision in a limited number of localities, where pharmaceutical supplies are not conveniently obtainable from a druggist or a public hospital, for the supply of drugs by medical practitioners. In such cases the medical practitioners are entitled to make claims for payment in the same manner as the druggists.

Rates of Payment - The amount that is paid for claims is assessed by the Department and is equivalent to the price of the goods supplied, computed in accordance with provisions of the Drug Tariff discounted at 2½ per cent, plus any additional dispensing fees authorized by the Tariff.

Vendors of pharmaceutical supplies, generally speaking, are required to accept payments from the Fund, in full settlement.

SUPPLEMENTARY BENEFITS(1)

(1) X-Ray Diagnostic Services

(a) Provided by Radiologists Employed by Hospital Boards

Method and Rate of Payment - In the case of in-patients receiving x-ray diagnostic services in public hospitals, the services are included in the payments for in-patient Hospital Benefits and Boards are not permitted to make any additional charges on the Fund for such services.

For services provided to out-patients, Boards are entitled to claim full payments from the Social Security Fund according to a schedule of fees set out in the X-ray Diagnostic Regulations. Claims are made to the Medical Officer of Health of the appropriate district.

(b) Provided by Radiologists in Private Practice

Methods of Payment - "Recognized" radiologists(2) in private practice must support their claims by a brief statement, setting out their reasons for rendering the

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(1) Information is not available at present as to the methods and rates of payments for two classes of supplementary benefits, specialist (neuro-surgery) and ambulance benefits.

(2) All radiologists before providing services under the benefits are required to apply for recognition from the Minister of Health and are then given "absolute" recognition or "limited" recognition depending upon their qualifications

services. All claims for payment are made to the Medical Officer of Health for the appropriate district.

Rates of Payment - Under the X-ray diagnostic regulations issued in 1941 the schedule of fees provided two scales, one for the fees payable to Hospital Boards providing these services to out-patients and to radiologists afforded "limited" recognition, and the other which is somewhat higher, for fees payable to radiologists whose recognition is "absolute". The latter scale of fees is somewhat higher.

Radiologists in private practice may, up to specified amounts, charge patients an additional fee to that payable from the Social Security Fund.

(2) Laboratory Diagnostic Services

(a) Provided by Pathologists Employed by Hospital Boards

Method and Rate of Payment - Hospital Boards are entitled to claim payment in accordance with a schedule of fees(1), for hospital board laboratory services provided to out-patients but may not claim any payments under the Laboratory Diagnostic Services Regulations for laboratory services provided to in-patients(2).

The prescribed fees received from the Fund must be accepted by the Boards as full payment.

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(1) The schedule of fees are given in the 'Social Security (Laboratory Diagnostic Services) Regulations' 1946, 1946/24.

(2) Laboratory services, like x-ray diagnostic services, are included in the "in-patient" services provided under the Hospital Benefits to patients in public hospitals, Social Security (Hospital Benefits) Regulations 1939 (Serial No. 1939/75).

Claims for payment are made to the Medical Officer of Health of the appropriate district.

(b) Provided by Pathologists in Private Practice

Method of Payment - Claims by private pathologists are submitted to the Medical Officer of Health of the appropriate district and must be accompanied, in cases where services have been provided on the recommendation of another medical practitioner, by a copy of the recommendation or, in cases where services have been recommended by the pathologist making the claim, by a statement giving the reasons for providing the services.

Rate of Payment - The fees payable are the same as those paid Hospital Board pathologists.(1)

Unlike private radiologists, private pathologists are required to accept Fund payments in full satisfaction of their charges.

(3) Dental Services

(a) Provided by State Dental Clinics

Method and Rate of Payment - The Dental Benefit Regulations stipulate that from time to time payments of amounts determined by the Minister shall be made from the Social Security Fund for the benefits provided by the State dental clinics.

(b) Provided by Dentists in Private Practice

Method of Payment - Private dentists who have contracted to provide services under the benefits, receive payment in full for service by submitting claims to the

(1) Originally private pathologists were paid at a higher rate than that paid to Hospital Boards providing these services.

Principal Dental Officer of the respective districts in which they practice; such claims must be submitted within two months after the date on which the services are provided.(1)

Rates of Payment - Generally speaking dentists are paid on a fee-for-service basis, with fees specified in the schedule issued in the Dental Benefit Regulations.(2) In any case where no definite fee is prescribed the dentists are paid a fee that is approved by the Principal Dental Officer.

(4) District Nursing Services

(a) Provided by Nurses Employed by Hospital Boards and Subsidized Associations

Method and Rate of Payment - The regulations(3) stipulate that the amount to be paid from the Fund to a Hospital Board providing district nursing services for any period must be in full settlement, and must not exceed an amount which is sufficient to meet the costs incurred or likely to be incurred in providing the services for that period. In computing the cost of the service for any period, account must be taken of such items as, the salaries of the personnel providing the services, their travelling expenses, the cost to the Boards for drugs, dressings and other materials used in the treatment of patients, and any other expenses incurred by Boards in providing the service.

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(1) Failure to comply with this ruling usually results in the payment from Fund being reduced by 10 per cent.

(2) Social Security (Dental Benefits) Regulations 1946 (1946/189).

(3) Social Security (District Nursing Services) Regulations 1944, (1944/105).

(b) Provided by Nurses Employed by a Department of State

Method and Rate of Payment - The Fund must make such payments for nursing services provided through a department of Government, as are stipulated by the Minister of Health.

(6) Massage Services

Method of Payment - The general arrangement for these benefits consists of individual contracts with registered masseurs under which they are paid a specified fee from the Fund for each recommended massage treatment provided. There are two rates of payment, one covering treatment given in the masseur's rooms and the other for treatment given elsewhere; no extra charge to the patient is allowed.

Rates of Payment - The two rates of payment for treatment are:

(i) 3s. 6d. for each treatment provided in the masseur's rooms;

(ii) 7s. for each treatment afforded elsewhere.

(7) Domestic Assistance

Method of Payment - Payments from the Fund are made from time to time to every approved association providing domestic assistance and these amounts are determined by the Minister, having regard for the following points:

(i) the expense incurred by associations providing the domestic assistance service, including the administrative expenses met by associations for such things as the organization of any scheme of registration or enrolment, or in the

training of women or girls who are willing to undertake domestic work in homes, including also any payments that might be made to girls under training;

(ii) the amounts received from or recoverable from householders by associations;

(iii) the terms of contract between associations and domestic assistants in their employ;

(iv) the terms of contract between the associations and various householders receiving the service.

VII ADMINISTRATION

This Chapter provides a brief description of the administrative organization of the National Health Insurance scheme, together with some general remarks on the relationships of the patient, physician, hospital, and other personnel, to the scheme.

PATTERN OF ADMINISTRATION

The Social Security Act established a new Department of State called the Social Security Department. Under the direction of its Minister, this department administers the various monetary benefits provided under the Act.

The health benefits are administered separately, by the Health Department under the direction of the Minister of Health. The Minister is authorized to appoint advisory committees from time to time to assist him in the formulation of the necessary administrative regulations regarding the benefits. Administrative powers in relation to the health benefits are delegated by the Minister to the Chief Administrative Officer of the Health Department, the Director-General of Health.

(1) National

The administrative organization of the Department of Health on the national level consists of a Director-General of Health and Divisions of Public Hygiene, Hospitals, Nursing, School Hygiene, Maternal Welfare, Tuberculosis, Dental Hygiene, and Health Benefits, each of which is under the supervision of a Director.

Direct responsibility for the administration of the health benefits is given to the Health Benefits Division of the Health Department.

(2) Local

The existing local public health units and public hospital facilities as organized under Hospital Board control are utilized for the administration of the benefits on the local level. Under the (public) Health Act 1920 the local health units were organized by districts, each of which is under the charge of a Medical Officer of Health who must be a medical practitioner with special qualifications in public health.

The duties of the local medical health officers in relation to health benefits include:

(i) receiving applications for recognition by the Minister from persons wishing to provide certain types of service under the benefits; for example, all pathologists wishing recognition to provide laboratory diagnostic services must send their applications for recognition to the Medical Officer of Health for transmission to the Minister;

(ii) disseminating information provided by the Minister pertaining to the health benefits;

(iii) receiving claims for payment and for refunds submitted by practitioners and patients respectively;

(iv) other duties relating to the adjustment of claims; and

(v) assisting maternity patients in the selection of hospitals or persons to provide benefits.

RELATIONSHIP BETWEEN GENERAL PRACTITIONERS AND THE HEALTH INSURANCE SCHEME

In New Zealand all general practitioners are free to enter into, or to remain outside of, the medical services schemes set up under the Social Security Act. Practitioners wishing to provide services simply contract with the government to do so. Even after they have entered into such a contract, medical practitioners are not bound to provide the services to every person who applies for them - they retain the right to refuse persons at their own discretion. However, a contract between the Minister and any practitioner may be terminated only after investigation by and on the recommendation of a special tribunal which consists of: (a) a President, who must be either a judge of the Supreme Court or a Magistrate; and (b) not less than two persons who are members of the same profession or calling as the person to whose contract the investigation relates.

(1) Relationship Between Patient and Doctor

In the case of the capitation scheme, a medical practitioner, as well as contracting with the government to provide medical services, must also enter into a formal agreement of service with those persons for whom he is willing to provide services. Regulations governing this patient-

doctor agreement are formulated so as to permit either the patient or the doctor to terminate the agreement subject to certain provisions. These provisions are sufficiently stringent as to insure some stability in the patient-doctor relationship while at the same time protecting the right of either the patient or the doctor to cancel the agreement.

Provision is also made under this scheme for the termination of the contracts between the Minister and the medical practitioners in any case where the Minister has made or proposes to make special arrangements for the provision of medical services; this provision allows the Minister to create salaried positions for medical officers serving in isolated areas.

In the case of the fee-for-service scheme, there is no contractual arrangement between the doctor and the patient and therefore no problem in regard to the right of a patient to change doctors or of a doctor to cease providing treatment to a patient. Under this scheme either party may make a change at any time.

RELATIONSHIP BETWEEN PRIVATE SPECIALISTS AND THE HEALTH INSURANCE SCHEME

Initially, only three classes of specialists received specialist rates of payment for the services they provided under the benefits. The remaining specialist services provided were subject to the fee paid for general medical services (7s.6d. per treatment). However, in the future, all specialist services will be remunerated at rates higher than

the general service rate.

In order to provide specialist services, it is necessary for private specialists to be recognized as being qualified in one of these specialties before entering into a contract to provide these services under the benefits. Recognition of radiologists and pathologists rests solely with the Minister, while in the case of obstetricians and other classes of specialists, it is (or will be) dependent upon the recommendation of an advisory committee of medical practitioners, appointed by the Minister.

Under hospital benefits, all types of specialist services are available to patients free of charge and are provided by practitioners in the employ of the hospitals.

RELATIONSHIP BETWEEN HOSPITALS AND THE HEALTH INSURANCE SCHEME

In the case of public hospitals, which are organized on a district basis and controlled by Boards consisting of elected local representatives, the contracts to provide treatment under the various benefits are made between the Boards and the Minister. Again it should be emphasized that the contracts stipulate that payment from the Fund shall be considered in full satisfaction for treatment provided - the Boards may not charge patients an additional fee.

In respect to the two classes of hospital benefits, for in-patients and for out-patients, the public hospitals provide by far the largest proportion of the treatment given under these benefits. The public hospitals also provide a major part of the benefits in respect of maternity services,

X-ray diagnostic services, and district nursing services. In short, the locally controlled public hospital system plays a primary role in the total health benefits program. While the Hospital Boards have control of internal administration, including all matters pertaining to treatment, they fall under the general advisory and supervisory control of the Director-General of Health.(1)

RELATIONSHIP BETWEEN OTHER HEALTH PERSONNEL AND THE HEALTH INSURANCE SCHEME

Except for individuals employed by Hospital Boards, all other persons providing the various services provided under the benefits, e.g., chemists, obstetric nurses, etc., must enter into a contract with the Minister. As in the case of the medical practitioners, these contracts may be terminated by the Minister only after an investigation by and on the recommendation of a special tribunal.

(1) Private hospitals, which are owned and operated by private licensees, must be approved by the Minister before entering into a contract to provide hospital benefits. Private institutions receive the same rate of payment from the Fund but may make additional charges to the patient.

APPENDICES

APPENDIX I

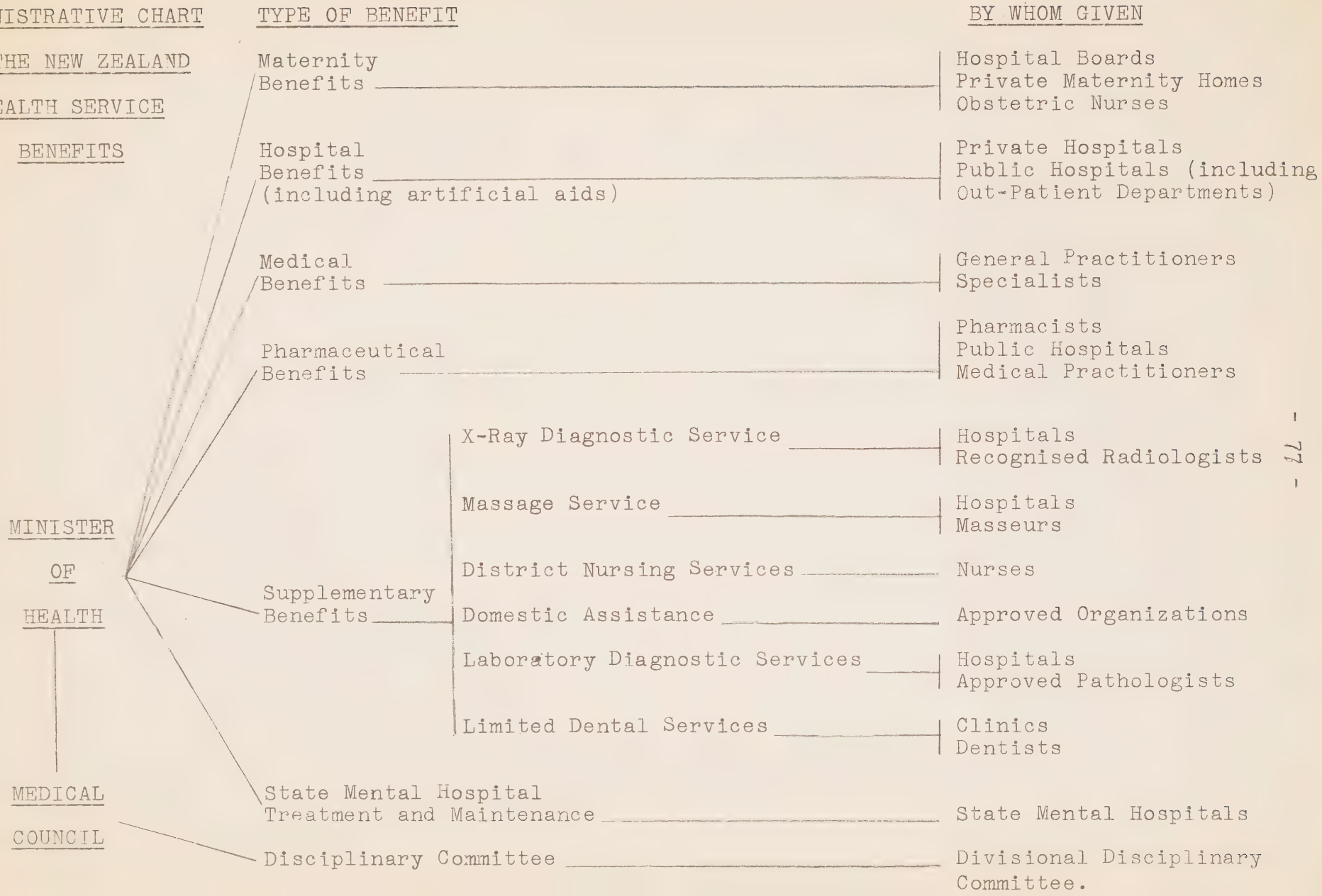
HEALTH BENEFITS AVAILABLE UNDER PART III OF THE SOCIAL SECURITY ACT, 1938, IN ORDER OF INTRODUCTION

Benefit	Date from Which Operative
Treatment in State Mental Hospitals	1st April, 1939.
Maternity Benefits	15th May, 1939.
Hospital Benefits (in respect of in-patient treatment)	1st July, 1939.
Hospital Benefits (in respect of out-patient treatment)	1st March, 1941.
"Medical Benefits" (capitation scheme)	1st March, 1941.
Pharmaceutical Benefits	5th May, 1941.
"General Medical Services" (alternative to capitation scheme)	1st November, 1941.
X-Ray Diagnostic Services	11th August, 1941.
Massage Benefits	1st September, 1942.
District Nursing Services	1st September, 1944.
Domestic Assistance	20th December, 1944.
Laboratory Diagnostic Services	1st April, 1946.
Dental Benefits	1st February, 1947.
Hospital Out-Patients Benefits (General)	1941.
Hospital Out-Patients Benefits (Artificial Aids) -	
Contact lenses	1st June, 1947.
Hearing-aids	1st November, 1947.
Artificial limbs	1st April, 1948.

APPENDIX II

ADMINISTRATIVE CHART OF THE NEW ZEALAND HEALTH SERVICE

BENEFITS



APPENDIX III

TOTAL HEALTH BENEFIT EXPENDITURES FROM THE SOCIAL SECURITY FUND, 1939-40 TO 1948-49

YEAR	Total Expenditures (total of Appendices B to F following)	Recoveries[a]	TOTAL
	£	£	£
1939-40	1,058,048	1,350	1,056,698
1940-41	1,777,608	923	1,776,685
1941-42	2,437,407	1,819	2,435,588
1942-43	3,722,907	1,728	3,721,179
1943-44	4,751,437	24,757	4,726,680
1944-45	5,298,729	64,015	5,234,714
1945-46	5,564,315	27,751[b]	5,536,564
1946-47	6,211,580	20,384	6,191,196
1947-48	7,021,488	47,630	6,973,858
1948-49	7,875,448	31,814	7,843,634

(a) These are mainly in respect of hospital benefits.

(b) Prior to 1st April, 1945, these recoveries were treated as credits in reduction of expenditure. For 1945-46 they were included in "Miscellaneous Receipts, Social Security Fund." This should be taken into account when comparing published figures relating to Social Security Fund expenditure.

Source: Social Security Department, New Zealand, The Growth and Development of Social Security in New Zealand, Wellington, N.Z., 1950.

APPENDIX IV

MEDICAL BENEFIT EXPENDITURES, 1941-42 TO 1948-49[a]

YEAR	Capitation Fees	Capitation and "General Medical Services" Mileage	"General Medical Services"	Salaried Service	TOTAL
	£	£	£	£	£
1941-42	114,608	21,166	69,808	-	205,672
1942-43	71,149	64,039	831,397	49,468	1,016,053
1943-44	55,610	60,392	1,026,073	37,256	1,179,331
1944-45	42,400	59,442	1,161,326	23,855	1,287,023
1945-46	38,084	68,965	1,291,448	28,812	1,427,309
1946-47	31,187	90,289	1,600,601	38,497	1,760,574
1947-48	22,945	109,522	1,993,806	41,553	2,167,826
1948-49	16,818	123,768	2,112,304	53,991	2,306,881

(a) Capitation scheme inaugurated March 1, 1941; "general medical services", fee-for-service scheme, inaugurated November 1, 1941. For diagnostic service expenditures, see Appendix F.

Source: Social Security Department, New Zealand, The Growth and Development of Social Security in New Zealand, Wellington, N.Z., 1950.

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APPENDIX V

MATERNITY BENEFIT EXPENDITURES, 1939-40 TO 1948-49[a]

YEAR	Public Hospital Fees	Private Hospital Fees	Medical Practitioners' Fees	Medical Practitioners' Mileage Fees	Obstetric Nurses' Fees	St. Helen's Hospital Fees	TOTAL
	£	£	£	£	£	£	£
1939-40	74,780	139,602	45,938	1,031	16,022	6,440	283,813
1940-41	106,834	216,086	161,638	5,663	21,101	7,653	518,975
1941-42	113,276	227,315	176,973	6,215	18,940	7,151	549,870
1942-43	110,217	207,575	158,208	5,089	15,089	9,046	505,224
1943-44	114,930	209,841	162,227	5,044	12,027	9,870	513,939
1944-45	133,946	210,675	158,409	5,647	11,117	10,940	530,734
1945-46	160,870	222,669	201,633	4,572	10,465	(contri-	600,209
1946-47	223,914	202,928	232,088	4,825	9,234	bution	672,989
1947-48	301,293	214,963	269,265	5,997	8,512	now	800,030
1948-49	389,416	221,061	291,246	7,715	6,682	abolished)	916,120

(a) Inaugurated May 15, 1939.

Source: Social Security Department, New Zealand, The Growth and Development of Social Security in New Zealand, Wellington, N.Z., 1950.

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APPENDIX VI

HOSPITAL BENEFIT EXPENDITURES, 1939-40 TO 1948-49[a]

YEAR	In Public Hospitals	Out-Patient	In Private Hospitals	In Approved Institutions (b)	Contribution to Consolidated Fund for —				TOTAL
					Mental Hospital	Queen Mary Hospital	Rotorua Sanatorium	Rotorua Soldiers' Hospital	
	£	£	£	£	£	£	£	£	£
1939-40	514,254	-	82,980	1,459	166,000	6,835	2,707	-	774,235
1940-41	893,251	-	141,737	37,873	171,000	10,060	4,712	-	1,258,633
1941-42	953,794	47,162	146,953	28,155	181,451	11,705	4,985	-	1,374,205
1942-43	1,020,319	70,720	191,647	38,819	181,869	22,872	4,563	10,150	1,540,959
1943-44	1,564,315	73,137	238,772	43,908	182,830	28,691	5,932	20,561	2,158,146
1944-45	1,689,233	83,412	259,489	56,504	187,942	28,032	6,425	19,663	2,330,700
1945-46	1,767,874	98,972	264,865	41,749					2,173,460
1946-47	1,593,367	97,287	251,581	44,053					1,986,288
1947-48	1,536,417	117,385	252,850	42,837	(contribution now abolished)				1,949,489
1948-49	1,560,483	141,530	245,000	50,362					1,997,375

(a) In-patient benefits inaugurated July 1, 1939; out-patient benefits inaugurated March 1, 1941.

(b) Treatment in approved institutions includes Ashburn Hall, Knox Home, Auxkland, and Karitane Hospitals, payments to latter being introduced in 1940, but dated back to 1st November, 1939.

Source: Social Security Department, New Zealand, The Growth and Development of Social Security in New Zealand, Wellington, N.Z., 1950.

APPENDIX VII

PHARMACEUTICAL BENEFIT EXPENDITURES, 1941-42 TO 1948-49[a]

YEAR	Drugs Supplied by -			TOTAL
	Chemists	Medical Practitioners	Institutions	
	£	£	£	£
1941-42	261,845	1,527	16,326	279,968
1942-43	530,695	5,891	26,661	563,247
1943-44	716,080	6,092	40,026	762,198
1944-45	933,490	6,231	40,516	980,237
1945-46	1,082,342	6,030	44,994	1,133,366
1946-47	1,389,638	5,879	44,169	1,439,686
1947-48	1,507,521	5,973	44,856	1,558,350
1948-49	1,727,556	8,262	57,341	1,793,159

(a) Inaugurated May 5, 1941.

Source: Social Security Department, New Zealand, The Growth and Development of Social Security in New Zealand, Wellington, N.Z., 1950.

APPENDIX VIII

SUPPLEMENTARY BENEFIT EXPENDITURES, 1941-42 TO 1948-49.

YEAR	Radiological (Aug. 11, 1941)	Laboratory (April 1, 1946)	Massage (Sept.1, 1942)	Specialist (neurosurgery)	District Nursing (Sept. 1, 1944)	Dental (1946)	Domestic Assistance (Dec.20, 1944)	Ambulance (a)	Artificial Aids (a)	TOTAL
	£	£	£	£	£	£	£	£	£	£
1941-42	27,962	-	-	-	-	-	-	-	-	27,962
1942-43	88,588	-	8,836	-	-	-	-	-	-	97,424
1943-44	109,426	-	27,331	1,066	-	-	-	-	-	137,823
1944-45	128,842	-	32,152	1,324	7,717	-	-	-	-	170,035
1945-46	132,806	-	35,569	2,260	58,880	-	456	-	-	229,971
1946-47	175,420	61,453	43,028	1,485	68,614	-	2,043	-	-	352,043
1947-48	209,059	90,306	47,510	121	82,756	105,109	2,865	-	8,067	545,793
1948-49	249,461	117,173	57,088	4,072	111,289	223,186	3,258	324	96,062	861,913

(a) £10,000 estimated for year ended 31st March, 1947, but not expended.

Source: Social Security Department, New Zealand, The Growth and Development of Social Security in New Zealand, Wellington, N.Z., 1950.

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APPENDIX IX

LEGISLATION AFFECTING HEALTH BENEFITS UNDER PART III OF THE SOCIAL SECURITY ACT, 1938

ACTS

Social Security Act, 1938 (Part III).

Social Security Amendment Act, 1939 (section 9-15).

Social Security Amendment Act, 1940 (section 8).

Finance Act (No. 4), 1940 (section 13-14).

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Finance Act (No. 2), 1942 (section 12).

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Social Security Amendment Act, 1947 (section 20-21).

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Maternity Benefits -

Social Security (Maternity Benefits) Regulations (1939/43).

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Social Security (Supplementary Maternity Benefits) Regulations (1939/93).

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Social Security (Maternity Benefits) Regulations, Amendment No. 2 (1947/126).

APPENDIX IX - Cont'd

LEGISLATION AFFECTING HEALTH BENEFITS UNDER PART III OF THE SOCIAL SECURITY ACT, 1938

REGULATIONS - Cont'd

Medical Benefits -

Social Security (Medical Benefits) Regulations (1941/24).

Social Security (Medical Benefits) Regulations, Amendment No. 1, (1943/156).

General Medical Services -

Social Security (General Medical Services) Regulations (1941/187).

Social Security (General Medical Services) Regulations, Amendment No. 1 (1942/13).

Commencement of Part III (Medical Services) of the Social Security Amendment Act, 1949 (1950/60).

Pharmaceutical Supplies Benefits -

Social Security (Pharmaceutical Supplies) Regulations (1941/66)

Social Security (Pharmaceutical Supplies) Regulations, Amendment No. 1 (1941/131).

Social Security (Pharmaceutical Supplies) Regulations, Amendment No.2 (1942/3).

Social Security (Pharmaceutical Supplies) Regulations, Amendment No. 3 (1943/155).

Social Security (Pharmaceutical Supplies) Regulations, Amendment No. 4 (1946/135).

Massage Benefits -

Social Security (Massage Benefits) Regulations 1942/255).

APPENDIX IX - Cont'd

LEGISLATION AFFECTING HEALTH BENEFITS UNDER PART III OF THE SOCIAL SECURITY ACT, 1938

REGULATIONS - Cont'd

X-Ray Diagnostic Services -

Social Security (X-Ray Diagnostic Services) Regulations (1941/122).

Social Security (X-Ray Diagnostic Services) Regulations, Amendment No. 1 (1942/14).

Hospital Benefits -

Social Security (Hospital Benefits) Regulations (1939/75).

Social Security (Hospital Benefits) Regulations, Amendment No. 1 (1943/98).

Social Security (Hospital Benefits for Out-Patients) Regulations 1941 (1941/49).

Social Security (Hospital Benefits for Out-patients) Regulations 1941, Amendment No. 1 (1944/179).

Social Security (Hospital Benefits for Out-patients) Regulations 1947 (1947/68).

District Nursing Services -

Social Security (District Nursing Services) Regulations (1944/178).

Domestic Assistance -

Social Security (Domestic Assistance) Regulations (1944/178).

APPENDIX IX - Cont'd

LEGISLATION AFFECTING HEALTH BENEFITS UNDER PART III OF THE SOCIAL SECURITY ACT, 1938

REGULATIONS - Cont'd

Laboratory Diagnostic Services -

Social Security (Laboratory Diagnostic Services) Regulations 1946 (1946/24).

Social Security (Laboratory Diagnostic Services) Regulations 1946, Amendment No. 1 (1949/60).

Dental Benefits -

Social Security (Dental Benefits) Regulations 1946(1946/189).

Social Security (Dental Benefits) Regulations 1946, Amendment No. 1 (1948/191).

NOTICES (N.Z. Gazette)

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Hearing aids: N.Z. Gazette No. 65, 6th November, 1947, p.1751.

Artificial limbs: N.Z. Gazette No. 17, 1st April, 1948, p. 353.

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